Welcome!

ABOUT YOUR CHILD

Today's Date: ____/____/____

Child's Name: _____

Child's Nickname: _____ ❑ Boy ❑ Girl

Reason For Visit: _____

_____

Birthdate: ___/___/___ Age: _____ Grade: _____

School: _____ SS#: _____

Child's Home Phone#: _____

Child's Home Address: _____
STREET ADDRESS

_____
CITY STATE ZIP

Referred By: _____

WHO IS ACCOMPANYING THIS CHILD TODAY

Name: _____

Relation: _____

Are You The Legal Guardian of This Child? _____

YOUR CHILD'S MEDICAL HISTORY

What Is Your Child's Blood Type? _____

List Any Allergies Your Child Has. _____

_____

List Any Prescription / Over The Counter Medications

Your Child Is Taking. _____

_____

List Previous Surgeries / Treatments with Dates.

_____

_____

Does Child Have or Ever Had Any Of The Following Illnesses.

❑ Measles ___/___ ❑ German Measles ___/___

❑ Scarlet Fever ___/___ ❑ Mumps' ___/___ ❑ Chicken Pox ___/___

❑ Cancer ___/___ ❑ Pneumonia ___/___

❑ Urinary Tract Infection ___/___ ❑ HIV/AIDS ___/___

❑ Rheumatic Fever ___/___ ❑ Diabetes ___/___ ❑ Tuberculosis ___/___

Other illnesses/accidents? _____

_____

DEVELOPMENT / NUTRITION

Birth Weight _____ Length at Birth _____

Sat Alone ___/___ Stood Alone ___/___

Walked Alone ___/___ First Words ___/___

First Tooth ___/___ Toilet Trained ___/___

❑ Breast Feeding ❑ Formula ❑ Vitamins/FE/Flouride

FAMILY INFORMATION

Parent's Marital Status:

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Mother's Name: _____

❑ Biological ❑ Step Mother ❑ Guardian

Mother's Current Physical Health Is: ❑ Good ❑ Fair ❑ Poor

Mother's Blood Type Is ____ and RH is _____

Birthdate: ___/___/___ Home Phone #: _____

Employer: _____ Work Phone #: _____

SS#: _____ D.L.#: _____

Father's Name: _____

❑ Biological ❑ Step Father ❑ Guardian

Father's Current Physical Health Is: ❑ Good ❑ Fair ❑ Poor

Father's Blood Type Is ____ and RH is _____

Birthdate: ___/___/___ Home Phone #: _____

Employer: _____ Work Phone #: _____

SS#: _____ D.L.#: _____

Who Is Responsible For Making Appointments?

❑ Mother ❑ Father ❑ Other (Below)

Name: _____

Work Phone #: _____

Home Phone #: _____

Please List Any Other Children (Please include birthdates and gender)

_____

_____

Please continue on back

INSURANCE INFORMATION

Primary Insurance Company

Co. Name:_____

Address:_____

Phone #:_____ Group # (Plan, Local, or Policy #):_____

Insured's Name:_____ Relation:_____

Birthdate:___/___/___ Insured's SS#:_____

Insured's Employer:_____

Secondary Insurance Company

Co. Name:_____

Address:_____

Phone #:_____ Group # (Plan, Local, or Policy #):_____

Insured's Name:_____ Relation:_____

Birthdate:___/___/___ Insured's SS#:_____

Insured's Employer:_____

In the Event Of An Emergency, Who Should We Contact?

Their Name:_____ Relation:_____

Work Phone #:_____ Home Phone #:_____

ACCOUNT INFORMATION

Person Ultimately Responsible For Account

Name:_____ Relation:_____

Billing Address:_____

Home Phone #:_____ Employer:_____ Work Phone #:_____

SS#:_____ Driver's License #:_____

Desired Method of Payment:

❑ Cash ❑ Check ❑ Credit Card and Card #_____ Exp. Date:___/___/___

Name As It Appears On Card:_____

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider, parent and patient.

Our office policy requires payment in full for all services rendered at the time of visit. The person bringing the patient to this office is responsible for the charges unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

I hereby authorize payment of benefits directly to provider of benefits due me for services rendered. I further authorize the physician and/or supplier to release any information required to process insurance claims.

I understand the above information, guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my child's medical status.

Date:___/___/___ Signature of Responsible Person:_____

Please recycle so that we may preserve the health of our planet.